TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Deanna Kern, D.C.

Respondent Name
Insurance Company of the State of Pennsylvania

MFDR Tracking Number
M4-16-1563-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $846.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the $846.24 that has been requested by Deanna Kern, DC for the 7/29/2015FCE she performed … has not been paid because of an invalid W9."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 29, 2015	Functional Capacity Evaluation	$846.24	$843.20

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the procedures for requesting medical documentation.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.

6. Submitted documentation does not include explanations of benefits dated prior to submission to Medical Fee Dispute.

Issues

1. Did the insurance carrier properly raise the issue of the requestor's W-9?
2. What is the maximum allowable reimbursement (MAR) for the disputed service?
3. Is the requestor entitled to reimbursement of the disputed service?

Findings

1. In their position statement, the insurance carrier stated that reimbursement has not been made to the requestor "because of an invalid W9." 28 Texas Administrative Code §133.307(d)(2)(f) states, in relevant part,

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Further, 28 Texas Administrative Code §133.240(d) states,

   > The insurance carrier may request additional documentation, in accordance with §133.210 of this title …, not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges.

   Review of the submitted documentation does not support that the insurance carrier presented a denial of reimbursement to the requestor prior to the request for medical fee dispute resolution, or that a request for additional documentation was requested in accordance with 28 Texas Administrative Code §133.210. Therefore, the division finds that the insurance carrier did not properly raise the issue of the requestor's W-9 and this issue will not be considered for this dispute.

2. 28 Texas Administrative Code §134.204(g) states, in relevant part,

   > The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title.

   28 Texas Administrative Code §134.203(c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is $56.20.

   For CPT code 97750-FC on July 29, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.458100. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 1.009 is 0.464140. The malpractice (MP) RVU of 0.02 multiplied by the MP GPCI of 0.772 is 0.015440. The sum of 0.937680 is multiplied by the Division conversion factor of $56.20 for a total of $52.70. This total is multiplied by 16 units for a MAR of $843.20.

3. The total MAR for the disputed services is $843.20. The insurance carrier paid $0.00. A reimbursement of $843.20 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $843.20.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $843.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 14, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.